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UNDER SECRETARY FOR HEALTH'S INFORMATION LETTER

REQUEST FOR PROPOSALS (RFP) FOR CARE COORDINATION IMPLEMENTATION PROJECTS

1. This information letter announces the opportunity for Department of Veterans Affairs (VA) Veterans Integrated Service Networks (VISNs) to submit proposals to obtain home-telehealth equipment to support the implementation and evaluation of care coordination programs that enhance the care of veterans with chronic disease conditions with the objective of making the home the preferred place of care. These programs and associated evaluation will involve the use of designated home-telehealth technologies to provide care to veterans with complex chronic conditions such as: diabetes, congestive heart failure, mental health disease, spinal cord injury, wound care and infectious disease.

2. Definitions

a. **Care Coordination.** Care coordination is a process whereby the ongoing condition of selected patients is assessed and monitored using telehealth technologies to pro-actively detect changes in indices that alert to the need for prevention, investigation, and treatment to take place that enhances the health of patients and prevents unnecessary and inappropriate utilization of resources. ***NOTE:*** *Attributes of an Ideal Care Coordination Service are: Mission - To coordinate the right care in the right place at the right time; Vision - The place of residence is the place of care; and Values - Teamwork, caring, advocacy, expertise, commitment, and visionary leadership.* Care coordination uses best practices that are derived from scientific evidence to bring together health care resources from across the continuum of care in the most appropriate, effective, and efficient manner to care for the patient.

b. **Telehealth Technologies.** Telehealth technologies are information technology-based tools that collect clinical indices in the form of vital signs, disease management data, still images and live video from an originating site where the patient is located. These data are sent via telecommunications networks to a remote site where they are received, reviewed and assessed by clinicians. Telehealth technologies enable a range of health care services to be provided that cross the usual constraining boundaries of geographic distance, time, and social and/or cultural borders. This range of health care services includes, but is not limited to: vital sign monitoring, disease management, wound care, and medication compliance management.

c. **Continuum of Care.** Continuum of care is the coordinated linkage of health care programs and interventions in a way that meets an individual's ongoing needs with the appropriate level and type of medical, psychological, health, or social care resources that have been accessed, as required, from primary, secondary, or tertiary health care sectors.

d. **Continuity of Care.** Continuity of care involves seamlessly passing the responsibility of clinical care of patients between practitioners so that care is delivered in a consistent manner across organizations, over time.

e. **Care Management.** Care management oversees the management of patients who are at risk of deteriorating and who utilize high levels of health care resources. These services include, but are not limited to, assessment, care planning and implementation, education, referral, coordination, advocacy, monitoring, and periodic re-assessment. Together with telehealth technologies and disease management tools these elements form the core basis for care coordination.

3. Background

a. In FY 2002, there were over 6.8 million enrolled veterans of whom 4.5 million received care in Fiscal Year (FY) 2002 from the Veterans Health Administration (VHA) at an annual cost of $21.3 billion. The health care needs of the veteran population are higher than the United States (U.S.) average, especially for mental health services. However, utilizing the Centers for Disease Control and Prevention (CDC) ratio, a conservative estimate for the veteran population would indicate that 4 million enrolled veterans have one or more chronic health conditions, with 1.64 million having restrictions in performing activities of daily living (ADLs), and 480,000 unable to live independent lives. This need is creating a major growth in the demand for VA services, particularly in terms of the requirements for long-term care. This increased demand is creating challenges in providing access to care for veterans and their caregivers using traditional modes of health care delivery.

b. From a population of 4.5 million current veteran patients, a needs assessment in Fiscal Year (FY) 2002 suggested that there are 14,000 to 17,000 patients who can immediately benefit from the models of care coordination that have been developed in VISNs 1, 2, 8, 11, and 17. Those models of care coordination programs improved the quality of care while simultaneously reducing cost of care in this population sub-set. This group represents 0.4 percent of the VA user population, and is identified by the combination of specific Diagnostic Related Groups (DRGs) and a total individual cost of care received of at least $25,000 per year. DRGs include congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, mental health disorders, and rehabilitation.

c. Care coordination requires the support of a range of telehealth technologies that include telemonitors, videophones, in-home messaging, disease management tools, computers with Internet chat rooms, and photography. Choosing the appropriate technology means matching it to the patient's needs and its usability. Care Coordinators utilize these technologies to determine patients' clinical needs, health status, and educational requirements. Using Care Coordination together with these commercial off the-shelf (COTS) technologies in accordance with a technology algorithm (contact John Peters at 202-273-8508 for a copy) has resulted in demonstrably improved outcomes in patient care. For example, over 90 percent of patients are satisfied with the technology used and the associated care coordination process. Significant improvements are seen in five of eight domains as measured by the SF-36V (a quality of life assessment tool) for the chronic medical disease population with no perception of any associated deterioration.

d. Implementing this proven model of care coordination with home-telehealth in a systematized manner achieves levels of patient satisfaction, improved functional status, and

resource utilization that indicate this model of care can significantly meet the challenges VHA faces in delivering long-term care to veteran patients.

4. Rating and Evaluation of Proposals. Proposals will be evaluated and rated for merit, innovation, and completeness in response to each of the elements outlined in Attachment A by an appointed panel of field and VHA Central Office staff.

a. Special emphasis will be given to the following aspects:

(1) Systematically and efficiently managing patient access to the appropriate level of care along the continuum.

(2) Providing health education, disease management, and ongoing care needs to patients, family, significant others, and staff, as appropriate.

(3) Focusing on the patient in the context of family, home and community needs by integrating an assessment of living conditions, individual and family dynamics, and cultural background into the patient's plan of care.

(4) Maximizing the efficiency of health care resource utilization.

(5) Working collaboratively with the patient, family and/or significant other, and members of the health care team to improve and/or promote patient satisfaction.

(6) Programs designed to link with State Domiciliaries and Assisted Living Facilities.

(7) The degree to which the technology infrastructure accords with the evolving care coordination and/or home-telehealth infrastructure that VHA is developing.

b. In rating and evaluating proposals particular credit will be given to proposals to coordinate care approaches for elderly, frail patients that:

(1) Promote non-institutional care,

(2) Are designed to preserve the pair bond, i.e., spousal cohabitation, and

(3) Promote models of functional independence.

5. Funding ***NOTE:*** *See Attachment B.*

a. Funding of up to $1 million each will be made available to six VISNs in FY 2004 for home-telehealth technologies that may include: videophones, computers for participating in chat rooms, home messaging devices and telemonitors.

b. The funding for these programs will be for non-recurring, 1-year support and the proposal needs to give details of how local continuation beyond the grant will be accomplished.

6. General References

a. Extrapolation from figures in CDC. National Diabetes Facts and Figures, 2000. www.cdc.gov.

b. Extrapolation from figures in Robert Wood Johnson Foundation. www.improvingchroniccare.org.

c. The Development and Expansion of Home-Telehealth in VHA: A paper summarizing the discussions and recommendations generated from a 2-day VHA meeting on Home Tele-health. April 2002.

d. VHA Home-Telehealth Toolkit.

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f. Field, M., ed. Institute of Medicine Report- Telemedicine- A Guide to Assessing Telecommunications in Health Care. National Academy Press, 1996.

g. Reid J. A Telemedicine Primer: Understanding the Issues. Innovative Medical Communications, 1996.

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n. Baer L, Cukor P, Jenike MA et.al. "Pilot Studies of Telemedicine for Patients with Obsessive-Compulsive Disorder," American Journal of Psychiatry. 1995, 152:1383-1385.

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s. Balas EA, Jaffrey F, Kuperman GJ, et.al. "Electronic Communication with Patients-Evaluation of Distance Medicine Technology," JAMA. 1997; 278:152-159.

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u. Grigsby B, Allen A. "5th Annual Telemedicine Program Survey-Part 1- United States," Telemedicine Today. June 1998:36-37.

v. American Psychiatric Association Resource Document on Telepsychiatry via Videoconferencing, APA Committee on Telemedical Services, 1998.

w. American Psychiatric Association: http://www.psych.org/pract_of_psych/tp_paper.html

x. VHA telemedicine: http://www.va.gov/telemed

y. Telemedicine Information Exchange: http://www.telemed.org

z. Federal Telemedicine Gateway: http://www.tmgateway.org

aa. Telemedicine Activities of National Library of Medicine: http://www.nlm.nih.gov

bb. Department of Defense telemedicine: http://www.matmo.org

cc. American Telemedicine Association: http://www.atmeda.org

dd. Medical College of Georgia telemedicine: http://www.mcg.edu/telemedicine

ee. University of Iowa telemedicine: http://telemed.medicine.uiowa.edu/index.html

ff. University of Vermont telemedicine: http://www.uvm.edu/infoconn

gg. East Carolina University telemedicine: http://www.telemed.med.ecu.edu

hh. Kansas University Medical Center: http://www2.kumc.edu/telemedicine/index.asp

ii. University of Virginia telemedicine: http://www.telemed.virginia.edu

jj. University of Arizona telemedicine: http://www.ahsc.arizona.edu/telemed

7. Requirements. Those interested in responding to this RFP need to review Attachment A that contains requirements for submitting a proposal.

8. Inquiries. Questions regarding this RFP should be directed to Adam Darkins, M.D., Acting Chief Consultant, Office of Care Coordination, at (303) 393-4645, e-mail: Adam.Darkins@mail.va.gov, or Patricia Ryan, Acting Associate Chief Consultant, Office of Care Coordination, at (727)-319-1285, e-mail: Patricia.Ryan@med.va.gov or Fax at (202) 273-9126.

Robert H. Roswell, M.D.
Under Secretary for Health

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ATTACHMENT A

REQUIREMENTS FOR SUBMITTING PROPOSALS

The intention of this Request for Proposal (RFP) is to provide funding to implement a systematized process of care coordination in six Veterans Integrated Service Networks (VISNs). All proposals need to be submitted in the following format:

1. ELEMENTS OF A PROPOSAL ***NOTE:*** *Elements a-f of the proposal need to be constructed in accordance with the Veterans Health Administration (VHA) home-telehealth toolkit which may be obtained from the Telemedicine Strategic Healthcare Group, Department of Veterans Affairs (VA) Central Office, Washington, DC. Contact John Peters 202-273-8508.*

a. **Target Populations and Needs Assessment**

(1) All prospective program applications must detail what sections of the veteran patient population they expect to serve. Populations such as the frail elderly with multiple chronic conditions, younger veterans with mental health problems, acute onset Congestive Heart Failure (CHF), low activities of daily living (ADLs), Stroke, Home-based Primary Care (HBPC), Diabetes, Spinal Cord Injury, Wound Care, Dementia patients, Infectious Diseases, Chronic Pain, and Anticoagulant therapy are examples of populations covered by existing care coordination models.

(2) Prospective programs must identify the populations they intend to treat and confirm that they can build their program to the level of being able to carry a total on-going caseload of at least 1,000 patients in their program within a year of its commencement.

b. **Care Coordination.** All prospective programs must indicate how they can implement Care Coordination. A licensed professional who coordinates care for a panel of patients across the continuum of care must undertake care coordination. The program must ensure that care is timely, appropriate, of high quality, and cost effective. The care coordination process must integrate the primary care provider (or providers) and other health care professionals and/or team members, other clinics, internal or external services, and community agencies. Care coordination must provide professional assessment, coordination, and planning of multiple health care services; and in doing so, act on behalf of the veteran to ensure that necessary clinical services are received and that progress is being made. In addition, the care coordination process provides ongoing evaluation of care management services.

c. **Access to Clinical Care.** All prospective programs must outline how the care coordinators will assist with meeting the needs and coordinating the care of the patient groups targeted in their proposal. Particular consideration will be given to programs that focus on helping fulfill the requirements of Public Law 106-117, that mandates the provision of non-institutional extended-care services and case management. Currently, the system deploys case and/or care managers in multiple ways but their role is usually geared towards episodic and service-specific care. Veterans with multiple complex health problems who are seen by primary and multiple specialty providers can therefore be assigned to several case managers and/or care

managers; care becomes fragmented as points of care multiply so integration between services is necessary. By transitioning a current role such as a primary care case manager or HBPC provider into care coordination, this fragmentation of care is avoided.

d. **Timeliness.** Programs must indicate how they will offer timely access to care and enhance communication between health care providers and patients and/or families and among health care providers. Care coordination must improve access to care for patients at high risk for decline. Pro-active monitoring needs to be made available: to address medical and rehabilitative needs to maximize level of functioning and quality of life; to prevent long-term care placement; and to allow patients to remain at home.

e. **Employment of Technology.** Prospective programs must employ the appropriate Food and Drug Administration (FDA)-approved technologies made available under a VHA national purchasing contract for the program, to provide the necessary access to clinical services to meet the needs of the identified patient groups targeted in the program.

(1) The budget for the technology must be developed using the technology algorithm (contact John Peters at 202-273-8508 for a copy). The choice of what mix of approved technologies is used is left to the program with the only one proviso, that the program is able to meet the required target of patient numbers within a year of receiving funding. How the installation, maintenance, and collection of equipment is to be undertaken must be described.

(2) The technologies must cover the following categories:

(a) Computer chat rooms,

(b) Telephones,

(c) Videophones,

(d) Cameras,

(e) In-home messaging devices, and

(f) Telemonitors.

NOTE: *Technologies in all the preceding categories are available via a national contract for each that is being undertaken in partnership with VHA's National Acquisition Center (NAC). The contact at the NAC is Patricia Benson; Contract Specialist, 708-786-5253, or by e-mail at: patricia.benson@med.va.gov.*

f. **Management Functions.** Each prospective program must undertake to adopt the required management practices (that have been demonstrated) to secure the expected patient outcomes safely, effectively, and within budget. These practices include:

(1) Clinical coding,

(2) Credentialing and privileging,

(3) Informed consent,

(4) Staff training, and

(5) Business tracking.

g. **Quality Evaluation.** Successful programs will be required to undertake routine outcomes evaluations of their programs using the appropriate scorecard (contact John Peters at 202-273-8508 for a copy). These will include:

(1) Utilization of services,

(2) Patient satisfaction, and

(3) Health status of patients.

2. FORMAT FOR THE PROPOSAL

a. Each proposal must begin with an executive summary no longer than two pages. This is to summarize information regarding the proposal and to quantify the veteran population needs that it will be addressing. It must identify the background specific to the program area for which a project (diabetes, congestive heart failure, Spinal Cord Injury and Disorder (SCI), etc.) is being proposed. This summary serves to briefly acquaint the reviewers with how existing care management resources will be adapted to undertake care coordination.

b. Next, each proposal must address of the elements described in paragraph 1 of this attachment.

c. Each proposal must use standard size paper (8 ½ x 11), single spaced, with 10 or larger font size. Number each page sequentially and limit the application to 15 pages in length.

d. Each proposal must to be reviewed locally with support indicated in accompanying letters from the facility Director and the VISN offices indicating support from clinical leadership, information, management input, and support for the proposal.

e. Each proposal must have a supporting letter from the VISN Chief Information Officer (CIO) and the Information Security Officer (ISO) to confirm that the technology proposed fits into the evolving national architecture for home-telehealth and that all relevant information security aspects have been considered.

f. Each proposal must be submitted with a cover letter containing the VISN contact information (name, phone, fax, e-mail, if available) for the clinical staff responsible for preparation and submission of the proposal.

3. TIMETABLE FOR SUBMISSION AND FUNDING

Proposals are to be submitted by August 4, 2003. Once all the proposals have been received, the review proceeds for 45 days, followed by funding as available to selected program sites. Equipment availability and patient enrollment is expected to start on, or around, October 1, 2003.

4. SUBMISSION

An electronic and ten paper copies of each application must to be submitted to:

Chief Consultant,
The Office of Care Coordination (11T)
Office of Patient Care Services
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

ATTACHMENT B

CONDITIONS FOR RECEIVING FUNDING

It is a condition of receiving funding that programs comply with the following:

1. Involve a minimum of 1,000 patients into the program within 12 months of commencing the program.

2. Have assigned an alpha code on the Decision Support System (DSS) by the Office of Care Coordination and use this in addition to the Veterans Health Administration (VHA)'s DSS primary and secondary stop codes designated for home-telehealth in Fiscal Year (FY) 2003. Care coordination activity that is not so coded will not be accepted.

3. The technologies used must be from the VHA national home-telehealth acquisition and must not involve research activities such as a Cooperative Research and Development Agreement (CRADA).

4. The models of care that are implemented must be those that have been evaluated and implemented as part of the previous Veterans Integrated Service Network (VISN) 8 or the 2003 multi-VISN care coordination proposal. ***NOTE:*** *For details contact the VHA Office of Care Coordination.* These requirements are to ensure the programs meet the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) standards and ensure that quality measurement can take place.

5. A standard quality monitoring evaluation must be adopted, i.e., one that has been devised by the leads on the 2003 multi-VISN care coordination proposal.

6. Programs must submit themselves for internal VHA licensing within 12 months of commencing patient care.